# Cassidy's Cause
# Therapeutic Riding Academy

6075 Clinton Rd
Paducah, KY 42001
270-554-4040 Office
270-554-0023 Fax

## PARTICIPANT'S APPLICATION & HEALTH HISTORY

**GENERAL INFORMATION**

Participant:_____

DOB:_____ Age: _____ Height:_____ Weight:_____ Gender: M F

Address:_____

Phone: Home: _____ Cell:_____ Email:_____

Employer/School:_____

Address:_____

Parent/Legal Guardian:_____

Address (if different from above):_____

Phone (if different from above):_____

Referral:_____

How did you hear about this program?_____

**HEALTH HISTORY**

Diagnosis_____ Date of Onset:_____

*Please indicate current or past special needs in the following areas:*

| | Y | N | Comments |
|---|---|---|---|
| Vision | | | |
| Hearing | | | |
| Sensation | | | |
| Communication | | | |
| Heart | | | |
| Breathing | | | |
| Digestion | | | |
| Elimination | | | |
| Circulation | | | |
| Emotional/Mental Health | | | |
| Behavioral | | | |
| Pain | | | |
| Bone/Joint | | | |
| Muscular | | | |
| Thinking/Cognition | | | |
| Allergies | | | |

MEDICATIONS (include prescription and over-the-counter, name, dose and frequency)

_____
_____
_____
_____

Describe your abilities/difficulties in the following areas (include assistance required or equipment needed):

**PHYSICAL FUNCTION** (mobility skills such as transfers, walkers, wheelchair use, driving/bus riding)

_____
_____
_____
_____

**PSYCHOSOCIAL FUNCTION** (work/school including grade completed, leisure interest, relationships-family structure, support systems, companion animals, fears/concerns, etc.)

_____
_____
_____
_____

**GOALS** (why are you applying for participation? What would you like to accomplish?)

_____
_____
_____
_____

Signature: _____ Date:_____

**Photo Release**

_____ I DO _____ I DO NOT consent to and authorize the use and reproduction by Cassidy's Cause Therapeutic Riding Academy, Inc., of any and all photographs and any other audio-visual materials taken of me for promotional material, educational activities, exhibits, electronic publications (including the World Wide Web) or for any other use for the benefit of the program.

Signed:_____ Date: _____

Signature of parent/guardian if volunteer is under 18 years of age

**Liability Release**

_____(Participant's Name) would like to participate in the Cassidy's Cause Therapeutic Riding Academy, Inc. program. I am aware there exist significant risks from horseback riding and horse related activities, including permanent paralysis and death, and that such injuries may occur despite all reasonable precautions by myself and Cassidy's Cause, its employees and/or agents. However, I feel that the possible benefits to myself/my son/daughter/ward are greater than the risk assumed. In consideration for being allowed to participate in the activities of Cassidy's Cause, I hereby, to the fullest extent permitted by law, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, as well as those of my son/daughter/ward, waive and release forever all claims whatsoever, known or unknown, whether at law or in equity, now or in the future, against Cassidy's Cause Therapeutic Riding Academy, Inc., its Board of Directors, Employees, Instructors, Therapists, Aides, Volunteers, Equines, Equine Owners, Equipment and Operating Site for any and all injuries and/or losses of whatever nature or description, including disability or death, I/my son/daughter/ward may sustain while participating at Cassidy's Cause Therapeutic Riding Academy, Inc. By execution of this release, I represent that I have the legal authority to bind myself and my son/daughter/ward. "Warning: Under Kentucky law, a farm animal activity sponsor, farm animal professional or other person does not have the duty to eliminate all risks of injury of participation in farm animal activities. There are inherent risks of injury that you voluntarily accept if you participate in farm animal activities."

Signature:_____ Date: _____

Signature of parent/guardian if rider is under 18 years of age

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## Participant's Consent for Release of Information

I hereby authorize:_____

To release information from the records of:_____ DOB:_____

The information is to be released to Cassidy's Cause Therapeutic Riding Academy Inc. for the purpose of developing an equine activity program for the above name participant. The information to be released is indicated below:

- ☐ Medical history
- ☐ Physical therapy evaluation, assessment and program plan
- ☐ Speech therapy evaluation, assessment and program plan
- ☐ Mental health diagnosis and treatment plan
- ☐ Individual Habilitation Plan (IHP)
- ☐ Classroom Individual Education Plan (IEP)
- ☐ Psychosocial evaluation, assessment and program plan
- ☐ Cognitive-behavioral management plan
- ☐ Other:_____

This release is valid for one year and can be revoked, in writing, at my request.

Signature:_____ Date:_____

Print Name:_____

Relation to Participant:_____

Please send material to:

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6075 Clinton Rd
Paducah, KY 42001

# Cassidy's Cause
# Therapeutic Riding Academy

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Date:_____

Dear Health Care Provider:

Your Patient_____ is interested in

(participant's name)

Participating in supervised equine activities.

In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

**ORTHOPEDIC**

Atlantoaxial Instability – include neurologic systems
Coxarthrosis
Cranial Defects
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

**NEUROLOGIC**

Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II Malformation/Tethered Coed/Hydromyelia

**OTHER**

Age – under 4 years
Indwelling Catheters/Medical Equipment
Medications – e.g., Photosensitivity
Poor Endurance
Skin Breakdown

**Medical /Psychological**

Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to Self or Others
Exacerbations of Medical conditions (RA, MS)
Fire Setting
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine-assisted activities, please feel free to contact the center at the address/phone indicated above.

Sincerely,
Angie Falconite
Executive Director

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**PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT**

Participant:_____ DOB:_____ Height:_____ Weight:_____

Address:_____

Diagnosis:_____ Date of Onset:_____

Past/Prospective Surgeries:_____

Medications:_____

Seizure Type:_____ Controlled: Y N Date of last seizure:_____

Shunt Present: Y N Date of last revision:_____

Special Precautions/Needs:_____

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

Braces/Assistive Devices:_____

*For those with Down Syndrome:* Neurologic Symptoms of Atlantoaxial Instability: ☐ Present ☐ Absent

***Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.***

| | Y | N | Comments |
|---|---|---|---|
| Auditory | | | |
| Visual | | | |
| Tactile Sensation | | | |
| Speech | | | |
| Cardiac | | | |
| Circulatory | | | |
| Integumentary/Skin | | | |
| Immunity | | | |
| Pulmonary | | | |
| Neurologic | | | |
| Muscular | | | |
| Balance | | | |
| Orthopedic | | | |
| Allergies | | | |
| Learning Disability | | | |
| Cognitive | | | |
| Emotional/Psychological | | | |
| Pain | | | |
| Other | | | |

To my knowledge there is no reason why this person cannot participate in supervised equine activities. I understand that Cassidy's Cause Therapeutic Riding Academy Inc. will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Cassidy's Cause for ongoing evaluation to determine eligibility for participation.

Name/Title:_____ MD DO NP PA Other _____

Signature:_____ License/UPIN #_____Today's Date:_____

Address:_____ Phone:_____